ANN ARBOR SPINE CENTER

Patient History Form

Name:____________________________________ Date:_______________________________________
Contact Phone Number:_____________________ Age:_______ Date of Birth:___________________
Insurance:____

Family Doctor/Internist:
Name:__________________________________
Address:________________________________
City, State, Zip___________________________
Zip__________________________________
Send them a letter? Yes No

Who referred you to us?
Name:______________________________________
Address:____________________________________
City, State,
Send them a letter? Yes No

Check all that apply:
____Injury on the job ____Auto accident injury ____Receiving disability income
____Legal proceedings pending ____Receiving workers comp. ____Working with a rehab nurse

Imaging: _____MRI _____CT _____X-Ray _____Myelogram _____Bone Scan

Are you employed? ____Yes ____No Occupation ____

Does this problem keep you from working? ____Yes ____No (If yes; date last worked:________)

Reason for Visit (Chief Complaint): ____
Describe the onset and/or cause of your problem: Date of onset:_______________

Have you ever had back or neck surgery? Please list procedures and dates: (please list any complications and outcome of surgery)

How long have you had BACK/NECK pain? ______ Years _____ Months _____ Weeks
How long have you had ARM/LEG pain? ______ Years _____ Months _____ Weeks

Circle the number on the line best describing your current BACK or NECK pain:

0	1	2	3	4	5	6	7	8	9	10
No pain					moderate pain					severe pain

Circle the number on the line best describing your current LEG or ARM pain:

0	1	2	3	4	5	6	7	8	9	10
no pain					moderate pain					severe pain

Reviewed with patient: Physician/PA Signature:____________________________Date:______________________

Describe the character (quality) of your pain:

Aching	Sharp	Exhausting	Vicious
Throbbing	Pinching	Tingling	Penetrating
Burning	Punishing	Lancinating	Tearing
Dull	Shooting	Stabbing	Pressure

Other: ____

What makes your pain better?

_____lying down	_____manipulation	_____physical therapy
_____sitting	_____exercise	_____aspirin
_____standing	_____prescription pain pills	_____Tylenol
_____walking	_____muscle relaxers	_____over the counter medications

other:____

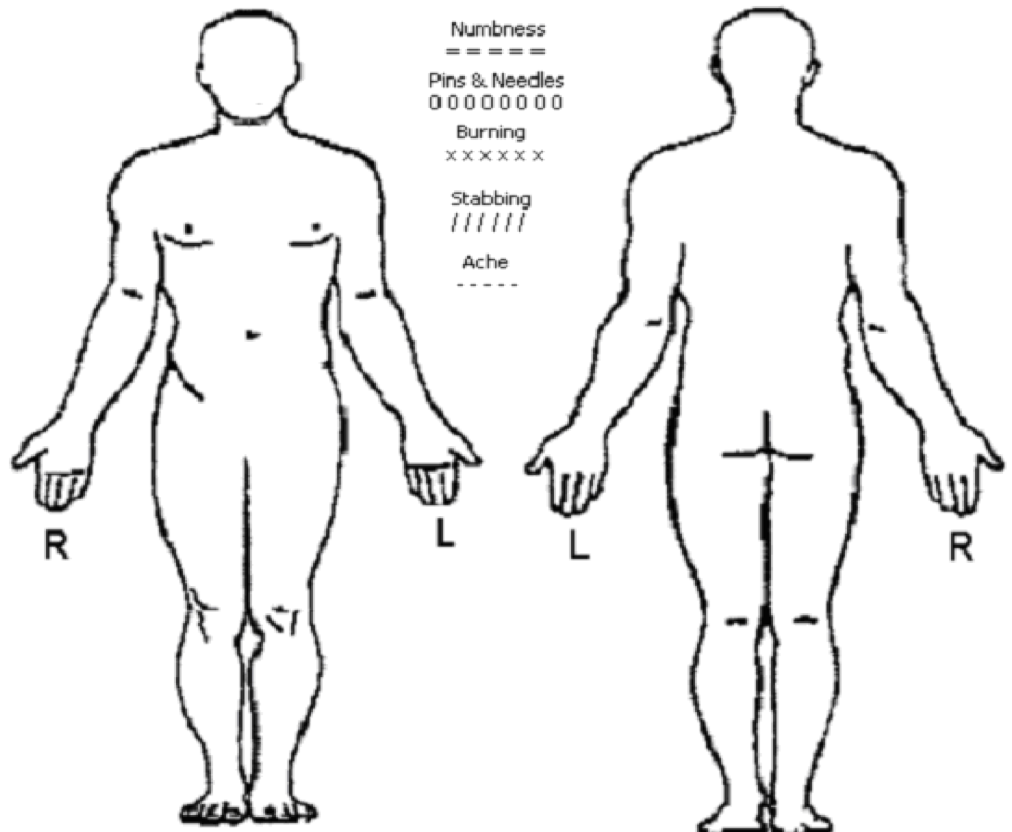
What makes your pain worse?

_____lying down	_____sneezing	_____exercise
_____sitting	_____coughing	
_____standing	_____bending forward	
_____walking	_____bending backward	

other:____

How far can you walk? _____ Blocks (number____) _____ Around the house
_____ Unlimited _____ other: ______________________

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the back of your neck, etc.).
If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.
If the markings are not applicable, indicate the areas of pain in your own words.



Name:________________________________

Who have you seen for treatment of pain/symptoms in the past? **(please list names also)**

- Primary care doctor ________________________________
- Orthopaedic Spine Surgeon ________________________________
- Neurosurgeon________________________________
- Rehab doctor________________________________
- Neurologist ________________________________
- Emergency room________________________How many times?________
- Pain clinic ________________________________
- Chiropractor________________________________
- Psychologist________________________________
- Psychiatrist________________________________
- Other ________________________________

Have you had: (check all that apply, include dates if known)

_____ X-rays _________________ _____ MRI _________________ _____ CAT scan ______________
_____ Bone Scan ______________ _____ EMG _________________ _____ Bone Density ___________
_____ Myelogram ______________ _____ Discogram ____________

What treatments have you tried for pain relief: (check all that apply)

Treatment	Did It Help?	
______ Physical therapy	YES	NO
Attended PT for how long?___________		
______ Aqua therapy	YES	NO
______ Traction	YES	NO
______ Massage	YES	NO
______TENS	YES	NO
______ Acupuncture	YES	NO
______ Anti-inflammatory meds	YES	NO
How long did you take medications?__________		
______ Pain medications	YES	NO
______ Worn a brace	YES	NO

Treatment	Did it help?	
______ Taken time off of work	YES	NO
______ Altered daily activities	YES	NO
______ Rested	YES	NO
______ Used ice	YES	NO
______ Used heat	YES	NO
______ Nerve Block	YES	NO
______ Facet Block	YES	NO
______ Oral Steroids	YES	NO
______ Epidural Steroid Injections	YES	NO

Past Medical History/Family History (check all that apply):

HEIGHT ______________ WEIGHT ________________

You	Family		You	Family	
_____	_____	Heart attack	_____	______	Bleeding problem
_____	_____	Heart failure	_____	______	Stress test
_____	_____	High Blood Pressure	_____	______	Cancer
_____	_____	Stroke	_____	______	Hepatitis
_____	_____	Kidney disease	_____	______	Pulmonary embolus
_____	_____	Heart catheterization	_____	______	Blood clotting
_____	_____	Diabetes	_____	______	High Cholesterol

List all past surgeries: (include dates if known)

____
____
____
____

Social History:

Are you married?	YES	NO	
Females—are you pregnant?	YES	NO	UNSURE
Do you smoke?	YES	NO	(# packs__________ for _________ years)
Do you use other forms of tobacco?	YES	NO	(What? ______________________)
Do you drink alcohol?	YES	NO	(# drinks weekly_________)

Allergies to medications and reactions (include tape and latex allergies):

____
____
____
____
____

Please list all current medications, supplements, vitamins, and herbs you take:

Drug	Dose	How many times taken daily

Review of Systems:

YES	NO	General
____	____	fever
____	____	weight gain
____	____	weight loss
____	____	sexual dysfunction
____	____	cancer
____	____	HIV

YES	NO	Ears, Nose, Throat
____	____	cold symptoms
____	____	headache
____	____	nasal drainage
____	____	sore throat
____	____	hearing loss

YES	NO	Eyes
____	____	sharp vision
____	____	glaucoma
____	____	cataracts
____	____	blindness

YES	NO	Heart
____	____	chest pain (angina)
____	____	palpitations
____	____	irregular heart beat
____	____	poor circulation
____	____	valve disease

YES	NO	Lungs
____	____	shortness of breath
____	____	cough
____	____	sleep apnea

YES	NO	Lymph Nodes
____	____	enlarged lymph nodes

YES	NO	Stomach (GI)
____	____	abdominal pain
____	____	diarrhea
____	____	constipation
____	____	nausea/vomiting
____	____	reflux
____	____	liver cirrhosis
____	____	loss of bowel control

YES	NO	Renal (Urinary)
____	____	renal failure
____	____	difficulty urinating
____	____	urgency
____	____	frequency
____	____	UTI
____	____	kidney stones
____	____	loss of bladder control
____	____	blood in urine

YES	NO	Muscle/ Bone
____	____	arthritis
____	____	osteoporosis
____	____	lupus
____	____	rheumatoid arthritis
____	____	sciatica
____	____	radiculopathy

YES	NO	Skin
____	____	rash
____	____	cancer
____	____	infection
____	____	psoriasis
____	____	eczema
____	____	ulcers

YES	NO	Brain/ Nerves
____	____	seizure
____	____	memory loss
____	____	paralysis
____	____	mini stroke
____	____	facial drooping
____	____	slurred speech

YES	NO	Blood Disorders
____	____	Sickle cell anemia
____	____	VonWillebrands
____	____	Hemophilia
____	____	Excessive bleeding
____	____	Easy bruising

YES	NO	Sleep/Psychological
____	____	Insomnia
____	____	excessive tiredness
____	____	anxiety
____	____	depression
____	____	manic depression